# Lecture 7 – Gender, Sexuality, and Mental Health

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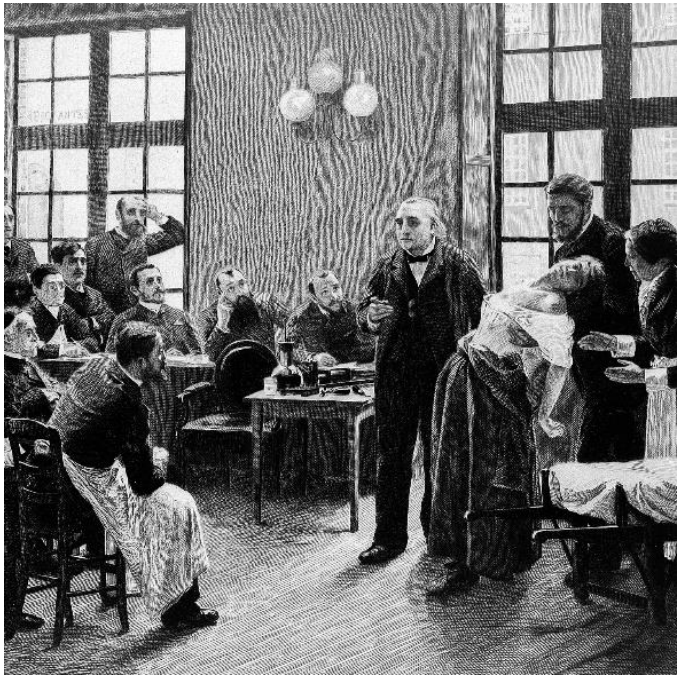
# Midterm!

- Reminder: no lectures/tutorials next week!.
- Midterm to be written an A2L under “quizzes” tab. Opens 12:01am on Nov 1st, closes 11:59pm on November 2nd.
- Covers readings and lectures up to (and including) this week’s material.

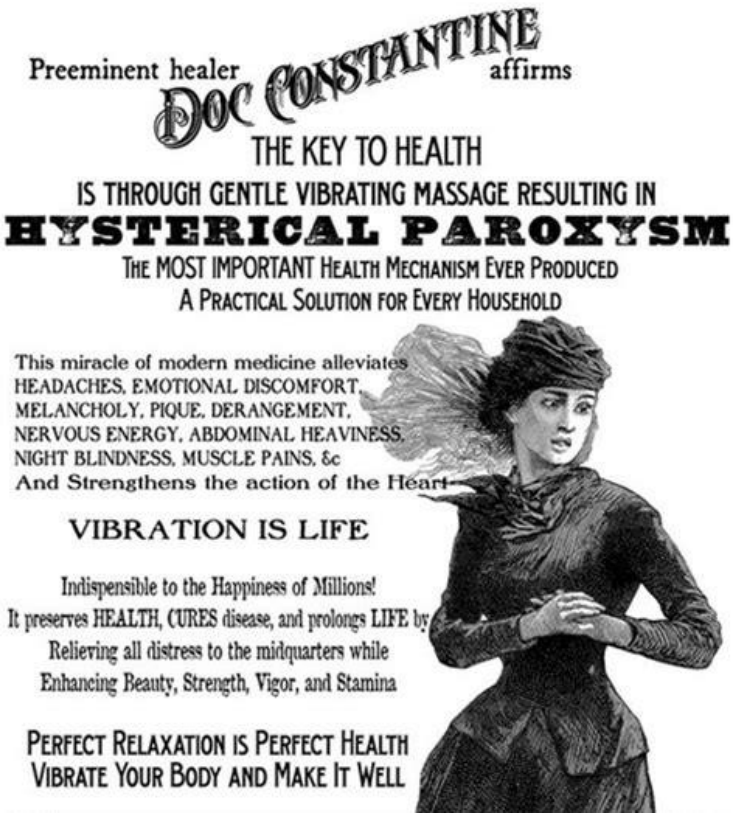
# Hysteria

- In this week's lecture, we examine intersections b/t gender, sex, sexuality, and mental health.
- Hysteria
  - Age old(?), w/ ever-changing symptomology (e.g. faintness, eccentricity, deceitfulness, sleeplessness, irritability, nervousness, pain, sensory change, exaggerated emotionality, etc).
  - Micale: a "dramatic medical metaphor for everything that men found mysterious or unmanageable in the opposite sex."



# Hysteria II

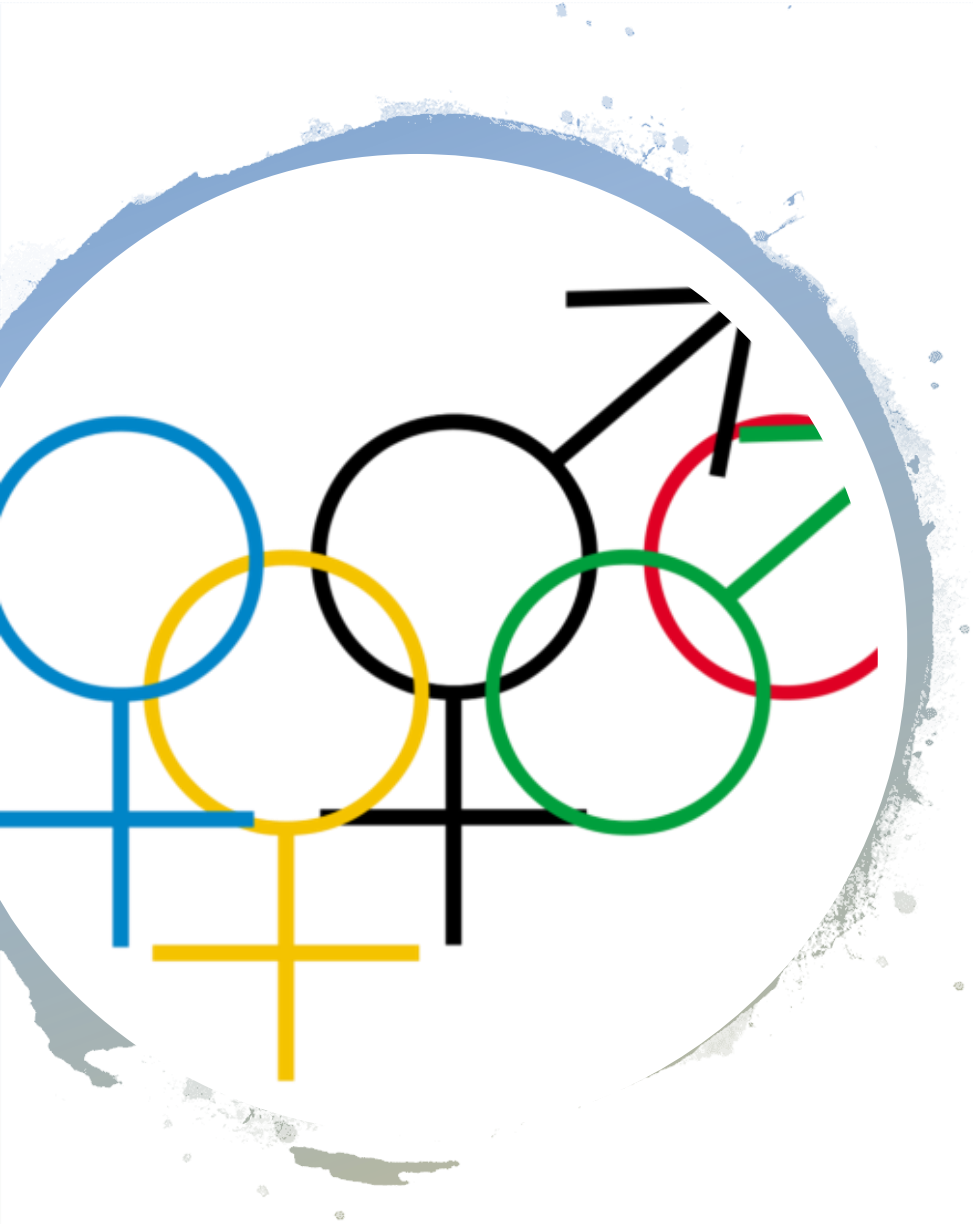
- Ancient world explanations blamed “a roaming uterus,” perhaps b/c womb barren.
  - Indicative of tendency to somatize women’s mental health.
  - Gender norms (and violation) linked to mental health.
- Medieval and early modern explanations sometimes centred on witchcraft.
- Post-IR, explained as consequence of women’s constitutional weakness.
  - Shifting symptomology reflected “unpredictable nature” of women’s bodies.
  - “Hysterical paroxysms” as treatment.
- Freud and others reimagined it along psychological lines.



# Uses of Hysteria

- Imagined symptoms and causes reflect shifting ideas about gender, including the behaviours “appropriate” for women.
- Both “pathologized and protected” women.
- Some cases might better be understood as a form of resistance against gender norms, e.g. suffragettes, divorcees, educated women.
  - Is medicalization a defensive (male) response to female assertiveness?
  - A (subconscious) strategy for the powerless? E.g. hysterical leg paralysis.

- Hysteria as evidence of:
  - How biological differences get used to explain mental health problems.
  - How expressions of distress themselves can be gendered.
  - How gender norms structure understandings of mental illness.



# Key Questions

- Do men and women experience same rates of mental pathology? What's at stake? How could we explain differences?
  - Is mental illness naturally occurring or the result of gender dynamics in society?
- How might distress be gendered?
- How can we understand the relationship between gender/sexual identity and mental health?

# Gender and Mental Health Imbalances

- "Intropunitive" emotions self-reported more often by women.
  - Diagnosed more often w/ anxiety, depression, EDs, some PDs.
- Men as "externalizers" (reporting more anger, aggression, etc.)
  - Diagnosed more often w/ substance-use disorders, anti-social behavioural disorders.

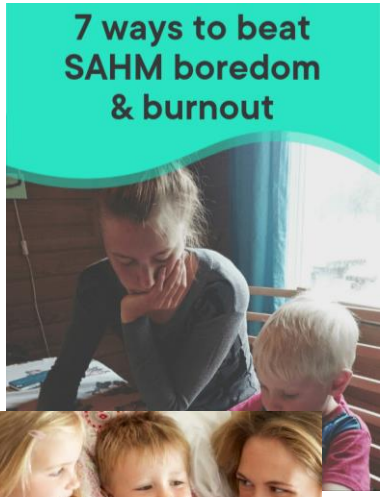
- Competing explanations:
  - Real differences based on physiology.
  - Real differences based on social conditions and socialization.
  - False differences based on research/diagnostic bias.

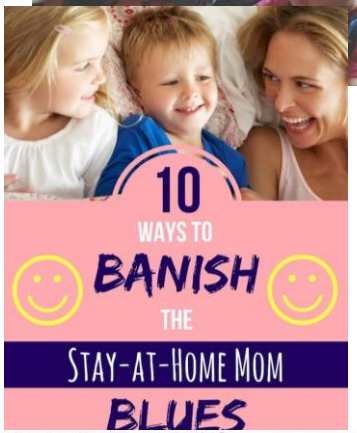
# Sources of Stress

- Women tend to self-identify as having mental health problems more commonly, also diagnosed at a higher rate. Is that related to greater distress?
- If women experience more distress, why might that be?
  - Exposure to harms.
  - Fewer resources.
  - Dual burden.
  - "Female roles" more stifling, less socially rewarding.
- Case study: "Supermoms"
  - "Intensive mother ideologies" linked to negative effects on mental health.
    - Increased stress, anxiety, guilt.
    - Decreased sense of self-efficacy.
  - Not only in "supermoms" but also those who spend time with them.

# Gender and Anorexia

- One commonly explored intersection b/t gender and mental illness relates to anorexia. Some theories:
  - An attempt to meet societally-approved thinness and beauty ideals.
  - "Good girls" and "people pleasers" seeking control.
    - Some feminist theorists support this theory, others reject it b/c it values "male personality traits" as ideal: autonomy, independence, emotional distance.
  - Post-structural feminists (Bordo, etc.): a form of resistance to maternal body and the "suffocating destiny of reproductive motherhood."




# Suicide

- One common finding: women attempt suicide more frequently, yet men are more likely to complete suicide. What might explain this?
  - Do higher rates of testosterone/aggression lead to more lethal attempts?
  - Could masculine gender norms make completed suicide more likely?
  - Could women's preferred methods reflect a gendered expectation to preserve beauty?
- These examples are all predicated on belief that real differences exist in the mental health problems experienced by women and men.

# Expressing Mental Disorder

- Are differences in rates of mental illnesses due to symptom expression, rather than actual differences in the problems that people have?

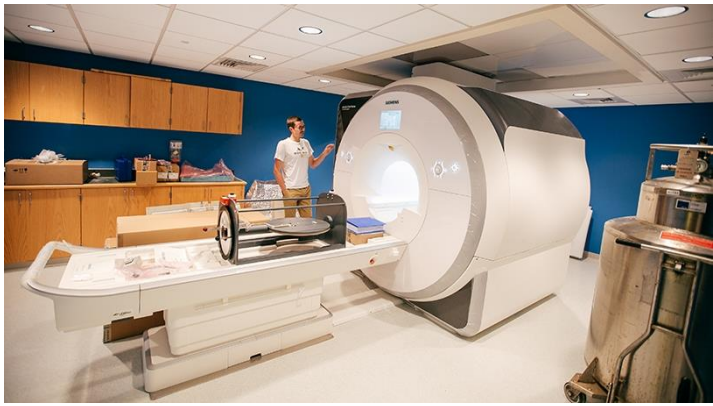
- One suggestion: female and male variants of depression, but only female one easily recognized by MDs:
  - "Female depression" – internalizing behaviours/feelings, somatic symptoms.
  - "Male depression" – exhaustion, irritability, restlessness, substance use.
- Others argue that depression and substance use go hand-in-hand for women AND men.

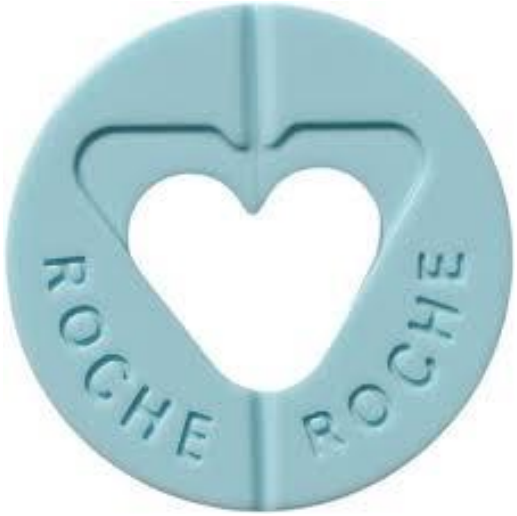
# Is It Reporting?

- Women report mental health concerns to MDs more often.
  - Is this about broader help-seeking behaviour and masculinity/femininity?
  - Men less likely to report certain mental health due to "feminine" nature.
    - Favour "non-mental health words," e.g. "burnout" v "depression."
  - Differences not solely related to gender. Some men more likely to report mental health problems, e.g. better educated, those w/ intimate partners, men w/ chronic illness & disability.

# Diagnostics and Treatment

- Could gender differences in rates be due to research/diagnostic bias?
- With non-immediately observable complaints, MDs tend to assume that men's problems are organic, whereas women's problems are psychosomatic.
- Women less likely to receive advanced diagnostic and therapeutic interventions, more likely to receive Rxs.





# Case Study: Female Sexual Dysfunction

- Some scholars point to mental disorders related to female sexual dysfunction as evidence of clinical and research bias.
- Female Orgasmic Disorder
  - "Any difficulty or delay in reaching orgasm that causes the woman personal distress." Can we separate distress from a culture that treats sex as transactional, where both parties should necessarily orgasm?
  - Diagnosable if a woman doesn't orgasm from "sufficient stimulation"…
- Sexual Interest/Arousal Disorder
  - US data: 32% of women "have it", more than 2x rate of men.
  - Symptoms include: "discrepancies in desire" and being "typically unreceptive to a partner's attempts to initiate."
    - Not considered a symptom in cases of "severe" relationship distress (i.e. violence), but other factors do not preclude diagnosis.

- For scholars, these disorders and their criteria heavily reflective of traditional medical (male) gaze.

# Queer Mental Health

- Sexualities and gender identities that do not fit within heteronormative ideal have had a fraught relationship with mental healthcare system.
- E.g. although homosexuality delisted in 1980, replaced w/ “ego-dystonic sexuality” until mid-1980s (describing anyone who felt distress over their same-sex attraction).
  - Again, can we separate this from social norms?
- Nonetheless, queer individuals appear to be at greater risk for poor mental health:
  - Mental disorder (50% more likely to be diagnosed)
  - Suicidal ideation (2-4x more common)
  - Greater rates of substance abuse
  - More likelihood of engaging in self-harm

# Sources of Distress

- Theories on sources of additional distress?
  - Prejudice, social exclusion, coming out process, internalized stigma, heteronormativity.
  - Significantly elevated rates of physical and sexual assault.
  - Could this be about broader social determinants?
    - E.g. In Ontario, >50% of trans individuals live on <$15k, much more likely to experience homelessness.
- Discrimination within care system itself?
  - Qualitative data from across North America suggests  many queer individuals may shun mental healthcare services.  Why?

# When Care Causes Distress

- Case Study: gender identity disorder, first appeared in DSM III.
  - DSM-IV e.g.: boys who want to wear dresses, girls who refuse to wear them…
  - Boys roughly 6x more likely than girls to be diagnosed with GID.
  - Like many diagnosed w/ homosexuality, conversion therapy applied to restore "normal gender identity."
- DSM-5: terminology shifted to gender dysphoria, the desire to be treated as a gender different than what society has assigned, to rid oneself of sex characteristics, or strong conviction that one belongs to a different gender.
  - "Gender nonconformity is not itself a mental disorder. The critical element is the presence of clinically significant distress."
  - Defenders: allows access to treatments, recognizes the distress.
  - Critics: such a diagnosis will doubtlessly impact identity. Moreover, in a society where discrimination against trans-individuals has a long history, why wouldn't a person be distressed?

# Conclusions

- Mental health differences between sexes and genders complex, related to social determinants, medical assumptions, and perhaps physiological differences.
- Throughout recent history, transgressing gender and sexual norms identified both as “proof” of mental disorder, as well as cause of distress.